Portsmouth Safeguarding Adults Board

Annual Report

PSAB

2021 - 2022

Statement from the Independent Chair

I am pleased to introduce the annual report of the Portsmouth Safeguarding Adults Board for 2021-22.

During the year, all coronavirus restrictions were lifted, with organisations slowly adapting to new ways of working, and the pressures that had been stored in the system becoming evident. Primary and secondary health services, alongside adult social care, had been strained, and people across all organisations felt exhausted. I want to pay tribute to all staff working to safeguard adults in the city of Portsmouth for their dedication and continued efforts.

As you will see from the Board's key achievements later in this report, our work to coordinate adult safeguarding has continued.

We have involved Alcohol Change UK in some new training, following the publication of a report: **How to use legal powers to safeguard vulnerable dependent drinkers.** The new training, for safeguarding staff across Portsmouth and the Isle of Wight, highlights the long-term effects of alcohol on executive brain functions, and how this affects mental capacity. Lessons learnt from this training are altering policy and practice for the better.

We began work on a policy to manage the risks for young people moving into adulthood, a comprehensive new approach which will bring significant benefits to young adults at risk.

We launched our new strategic plan, which puts engagement at the heart of the Board's work. We also created a new subgroup to bring together those working, both formally and informally, to safeguard adults, with the aim of pooling our knowledge and experience about adults at risk in the city, and exploring new ways of working with these adults.

We also engaged with several safeguarding adults reviews, with two completed during the year. The recommendations from these two important but tragic cases are helping to improve the way services are delivered.

David Goosey

Independent Chair

Our vision

"Working throughout the city with our communities and other partnerships to make Portsmouth a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business."

Our strategic priorities

During 2021-22 we refreshed our strategy, aiming to be more ambitious and link with the work of other strategic partnerships in Portsmouth including the Health and Wellbeing Board.

We consulted widely with stakeholders and engaged our membership about our future direction. With the continuing impact of the COVID-19 pandemic on services, we agreed that the strategy would be underpinned by a one-year action plan initially. We plan to review the strategy in 2022-23 to consider what has been achieved and how future progress should be made.

The strategy and action plan both set out the following priorities:

1. **Community engagement**: to engage more effectively with our service users, carers and communities, including people from groups we have not always engaged with in the past, such as homeless adults and adults who misuse substances.
2. **Interprofessional practice and relationship-based practice**: to build a competent, confident workforce, by supporting professionals from different agencies to work together. We plan to promote the use of the Multi-Agency Risk Management framework, strengthen professional supervision, and provide more opportunities for multi-agency training and sharing of good practice.
3. **Safeguarding practice**: to continue our efforts to review experience when things have not gone as planned and to publicise best practice.

Work will start on the new action plan in 2022-23.

Case study**: **Fire safety framework (Jane*)

Jane was a single lady who lived alone in a first-floor flat owned by a housing association. She found walking difficult and at times also experienced poor mental health. There was a high level of hoarding in all rooms and the exit from the flat was blocked with clutter. Apart from having someone come to service her gas, she was distrustful of services and did not let anyone into her flat. There were multiple ignition sources in the flat.

Jane's housing association worked with her over a period of months to build her trust, initially speaking to her through her letterbox until she felt able to let them in. The member of staff used the 4LSAB hoarding guidance and completed a hoarding risk assessment. They also worked with other agencies, supporting Jane into therapy via her GP, and referring her to adult services.

Using the new fire safety framework, they also identified that Jane was vulnerable to fire risks due to the issues affecting her and her environment. They referred Jane for a 'Safe and Well' visit from Hampshire and Isle of Wight Fire and Rescue Service, and completed a 'person-centred fire risk assessment'. Jane was issued with smoke alarms and fire-retardant bedding, and professionals helped her to understand what she could do to reduce the risk of a fire.

*Name changed to protect identity

Key achievements in 2021-22

This year the Board has:

- Developed a new **4LSAB Fire Safety Framework** to provide professionals with support and guidance for the effective management of fire risks within the home or residential care setting. The four Boards held an online launch event which was attended by 135 people
- Published a new **Safeguarding Adults Review Policy** which incorporates the best practice identified in a national review of SARs
- Reviewed and revised the **4LSAB Multi-Agency Framework for Managing Allegations Against People in a Position of Trust** and **4LSAB Multi-Agency Learning and Development Guidance for Safeguarding Adults**
- Delivered online webinars with Hampshire SAB on **Safeguarding Concerns,** which were attended by 232 staff from a range of organisations
- Delivered six online training sessions with Isle of Wight SAB on **Safeguarding Vulnerable Dependent Drinkers: Using legal frameworks to protect high risk, chronic dependent drinkers,** part of a national project led by Alcohol Change UK. Findings from the project were presented to Board members and other strategic leaders in October 2021
- Completed **multi-agency audits** to provide assurance to the Board about the effectiveness of safeguarding in Portsmouth. The first was on the quality of safeguarding referrals submitted to the Adult MASH and the quality of decision-making about these referrals. The second was on the use of the

Multi-Agency Risk Management Framework (MARM) and included a staff survey to help the Board understand the perceptions and experiences of professionals using MARM. Action plans were developed following these audits

- Begun working on a new **Multi-agency Framework for Managing Risk and Safeguarding People Moving into Adulthood**. The aim of this work is to strengthen the safeguarding support available to young adults aged 18 years with pre-existing vulnerability and risk factors as they move into adulthood. It recognises that safeguarding arrangements for young adults need to take account of their distinct safeguarding needs. This framework will be completed and published in 2022-23
- Worked with the Portsmouth Safeguarding Children Partnership (PSCP) to set up a **Harmful Practices Group**. Harmful Practices includes abuse such as: honour-based abuse, forced marriage, and Female Genital Mutilation (FGM). The group is a multi-agency forum which includes community groups. It commits to working together to end harmful practices and to ensure there is appropriate support for all adults, children and young people who have experienced, or are at risk of, this type of abuse. The group led on activities linked to **FGM Zero Tolerance Day** including a training session for professionals, lesson plans for schools, and masterclasses for teachers
- Established a new **Engagement subgroup** to lead on developing and maintaining strong links with the community to ensure effective safeguarding
- Held new **workshop-style Board meetings** to promote discussion of key issues. One such workshop involved voluntary sector partners and looked at how organisations can work together more effectively to support people who have multiple and complex needs, such as: substance misuse, mental health issues, and homelessness
- Received analysis of data and learning from the new **Drug Related Deaths** process which is led by Portsmouth City Council Public Health
- Conducted a **training needs analysis** and met with workforce development leads from partner agencies to review the analysis and identify priority areas for multi-agency training
- Supported **National Safeguarding Adults Week 2021**. Working jointly with the other 4LSABs, the Board developed and promoted resources on a different key topic each day using our website and social media
- Chaired the **4LSAB Coordination and Liaison Working Group.** The group brings together the statutory partners of all the 4LSABs to discuss strategic issues affecting safeguarding across the region. The business included discussion of the implications and practicalities of the health sector reforms and establishing of the new Integrated Care Systems, homelessness, and domestic abuse

Learning from Safeguarding Adults Reviews

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must take place when: 'there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or others worked together to safeguard the adult, and death or serious harm arose from actual or suspected abuse'.

The Care Act also gives Safeguarding Adults Boards the discretionary power to review cases where these criteria are not met.

The Board has a SAR subgroup which is multi-agency, with members who have a specialist role or experience in safeguarding adults. The group holds monthly meetings and during 2021-22 met jointly with the PSCP Learning from Cases Committee (LfC) when there were cases involving both children's and adult services.

Summary of SAR activity during 2021-22

The Board published two SARs in 2021-22, 'YL' and 'Pamela Ratsey', the findings of which are outlined in the next section.

Two reviews which were initially commissioned in 2019-20 are still ongoing and are due to be published in 2022-23. Due to the COVID-19 pandemic, work on these reviews was paused and they have therefore taken longer than usual to complete.

Two referrals were carried forward from 2020-21 as they were subject to an internal review by the referring agency. The SAR subgroup considered the findings from these and concluded they did not meet the criteria for a mandatory review as there was no multi-agency learning identified and the agency had already put in place an action plan to address its findings.

There were 15 new SAR referrals received in 2021-22. Four of these related to the deaths of people who had experienced self neglect in the period leading up to their

deaths. Following a review of the information held by different agencies about these people, the subgroup concluded that the criteria for a mandatory review were not et. For one of these cases, a meeting with the landlord (a housing association) identified some learning about the process for flagging and checking in with tenants who may be at risk. This learning was shared with other landlords in the city by Portsmouth City Council, who have this year set up a safeguarding forum. In view of the number of self neglect deaths identified, the SAR subgroup recommended to the Board that some assurance work on self neglect should be carried out in 2022-23 and the Board accepted this recommendation.

Two further referrals were considered but were also not found to meet the criteria for a mandatory review. In one case, actions were identified for individual agencies through a safeguarding enquiry that had been carried out by Adult MASH under section 42 of the Care Act, and plans were put in place to address these actions.

The remaining nine referrals were for the deaths of homeless people, who were either rough-sleeping or housed in temporary accommodation. None of these cases met the criteria for a mandatory review. In 2020-21, the Board commissioned a thematic review of homeless deaths to examine the issues relevant to such deaths in detail, using four cases as examples. The review will conclude in 2022-23 and will provide findings and learning relevant to the referrals for homeless people received this year.

YL Safeguarding Adults Review

The YL SAR was published in November 2021. YL was a young woman in her early twenties who had a history of mental illness and a diagnosis of Emotionally Unstable Personality Disorder. YL was also the mother of a young child. When her mental health began to deteriorate, she was placed in temporary accommodation due to the perceived risk to her child. YL's self harming behaviour began to escalate and she tragically took her own life some months later.

The SAR was conducted by an independent reviewer and the key findings were:

1. The multiagency partnership did not always work in partnership effectively.
2. Appropriate assessments were not always completed so needs were not always identified or risks mitigated.
3. Support was not always provided to meet identified need.
4. The voice of the adult was not always heard.
5. Safeguarding practice was not always optimal.

The Board accepted the findings of the review and a multi-agency workshop was held with senior managers from partner agencies to develop an action plan. Actions planned or underway include:

- Update and promote the Family Approach protocol and resources
- Develop guidance on supporting people who are or may become homeless including the 'Duty to refer'
- Ensure that the findings inform service development and the implementation of the Community Mental Health Framework

- Develop training and materials for staff on Emotionally Unstable Personality Disorder
- Review discharge-planning to ensure care and support needs are assessed as part of the discharge plan
- Develop a referral pathway to ensure early consideration is given to the care and support needs of adults at risk placed in temporary accommodation
- Build relationships between Children's Social Care and Mental Health services.
- Develop understanding of the Care Act 2014 and services for carers among Children's Social Workers.

The action plan is being monitored by the Quality Assurance subgroup.

Pamela Ratsey Safeguarding Adults Review

The Pamela Ratsey SAR was published in January 2022. It was the family's wish that Pamela's full name be used in the review instead of a pseudonym. Pamela was an older person who lived in Hampshire and was placed in a Portsmouth residential care home by Hampshire County Council. Concerns were raised by her family and other agencies about poor care and neglect, and a safeguarding enquiry was carried out by Portsmouth City Council. Pamela sadly died as a result of pneumonia and a pressure sore. The coroner found that neglect contributed to her death.

An independent reviewer carried out the SAR and the key findings were:

1. There was minimal engagement with Pamela's family and services did not seek their views or listen to their concerns.
2. There was a lack of clarity and consistency in the consideration of Pamela's mental capacity.
3. There was a lack of professional curiosity and risk management.
4. Pamela’s complex care needs were neglected at the home, and internal concerns about managing these needs were not shared with the placing authority or on hospital discharge.
5. Several services did not escalate concerns about Pamela’s increasing needs
6. Safeguarding enquiries were not personalised and did not effectively reduce the risk of neglect.
7. There were delays in reviewing Pamela's care and arranging for her to move.

The reviewer identified a number of improvements which had been made since the incident to address these findings, including the introduction of a Quality Improvement Team, new processes within the Adult MASH, improved electronic recording practices within Community Nursing, and a new Pressure Ulcer Panel.

The Board accepted the findings of the review and an action plan has been developed. Actions include:

- Review of the Multi Agency Risk Management Framework
- Improving cross border communication between Portsmouth City Council and Hampshire County Council about high-risk cases
- Reviewing the safeguarding information available for care homes

- Assurance work on Mental Capacity and reviews of care plans.

4LSAB Fire Safety Development Subgroup

The 4LSAB Fire Safety Development subgroup continues to review and share learning from serious fire incidents to ensure that effective inter-agency processes, procedures and preventative practices are in place.

In 2021-22 a total of four incidents, involving four injuries and one fatality, met the Fire Safety Development Subgroup criteria for review in the Portsmouth local authority area. One incident resulted in two injuries. It should be noted that, for the fatality reviewed, the cause of death is yet to be determined as the case is awaiting the Coroner's verdict at the time of writing.

For each of the cases a full review of the individual's risk factors, their supporting agencies and the cause of incident was conducted by the subgroup. In terms of the identified risk and vulnerability factors, the following themes emerged from these reviews:

- For 40% of the incidents reviewed, it was confirmed that the individual involved **lived alone**, and 20% identified the individual as being **homeless**.
- The **average age** of the individuals involved in the incidents reviewed was **66**.
- For 80% of the cases reviewed, the **gender** of the individual involved was **male**.
- For 40% of the cases reviewed, the individuals were known to Portsmouth Adult Services and were **in receipt of care and support services**.
- None of the cases reviewed identified hoarding and self neglect as a vulnerability factor.
- For 40% of the cases reviewed, **poor mental health** was identified as a vulnerability factor.
- For 20% of cases reviewed, **poor mobility** was identified as a vulnerability factor
- For 20% of cases reviewed, **substance misuse** was identified as a vulnerability factor

In reviewing causes of fire, the following themes emerged:

- 40% of the cases reviewed identified the most likely cause as ‘Accidental – carelessness with smoking material’.
- For the case resulting in two injuries (40%) the cause was identified as a gas explosion.
- 20% of the cases reviewed identified the most likely cause of the incident as ‘Accidental – unattended cooking’.

In December 2021, the subgroup reviewed its work and identified a series of best practice pointers.

Safeguarding activity in Portsmouth

Safeguarding Duty

Under Section 42 of the Care Act, a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect:

- that an adult has needs for care and support (whether or not the local authority is meeting any of those needs) and
- is experiencing, or is at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

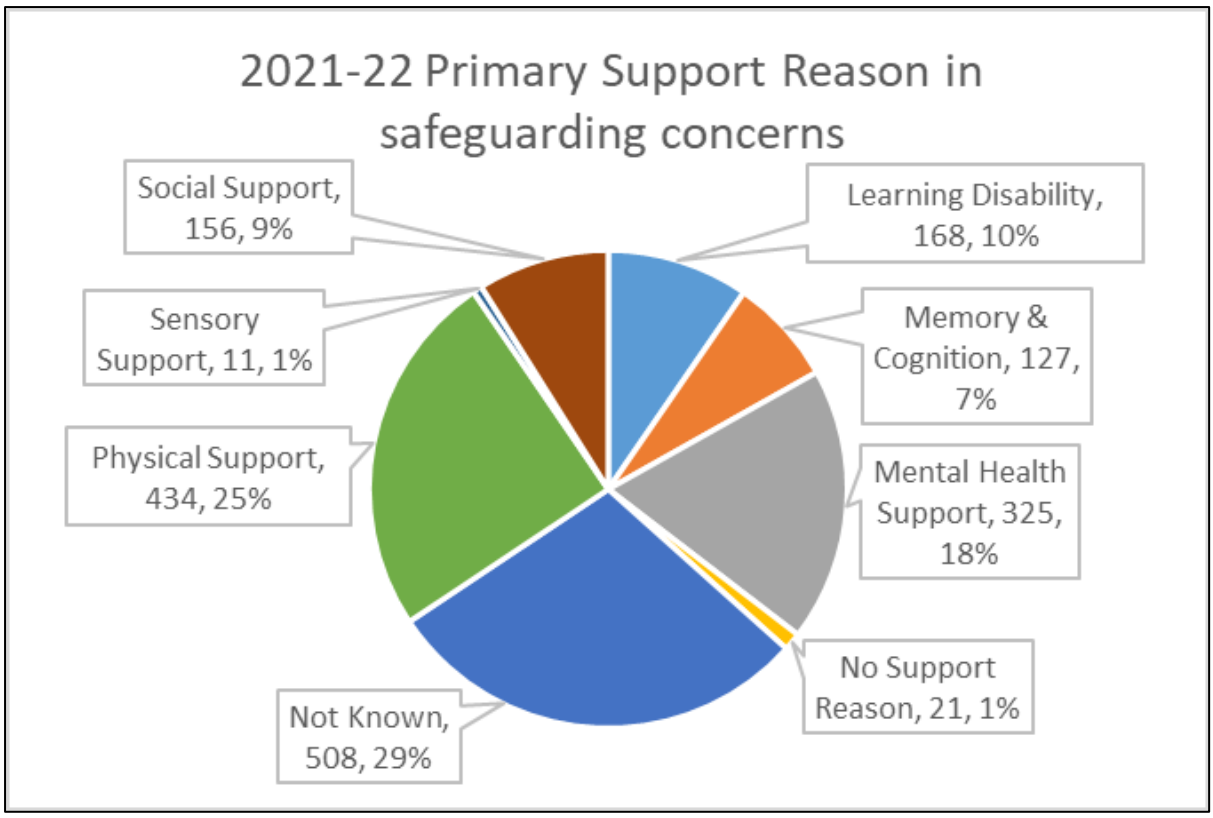
Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH) with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards and children's safeguarding. The MASH manages a high volume of referrals.

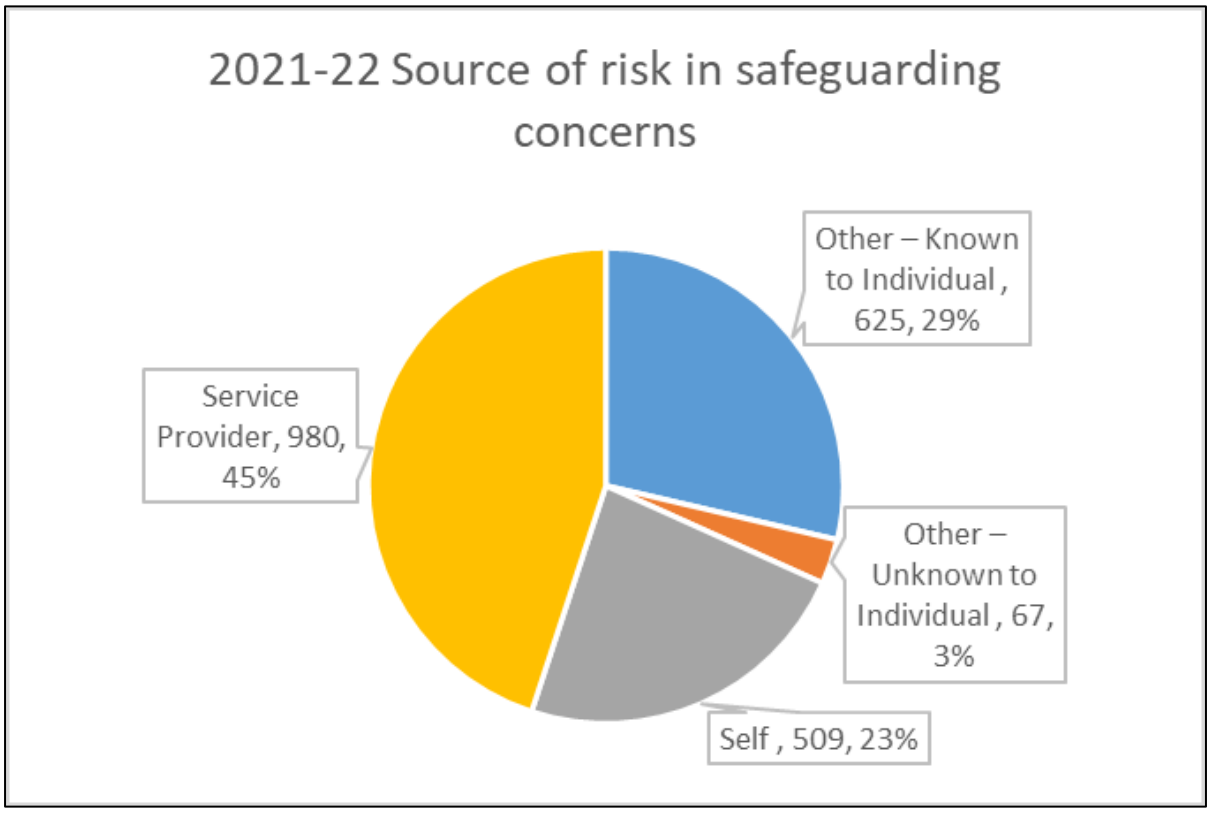
Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced. The information below is taken from the NHS Digital Safeguarding Adults Collection end of year return.

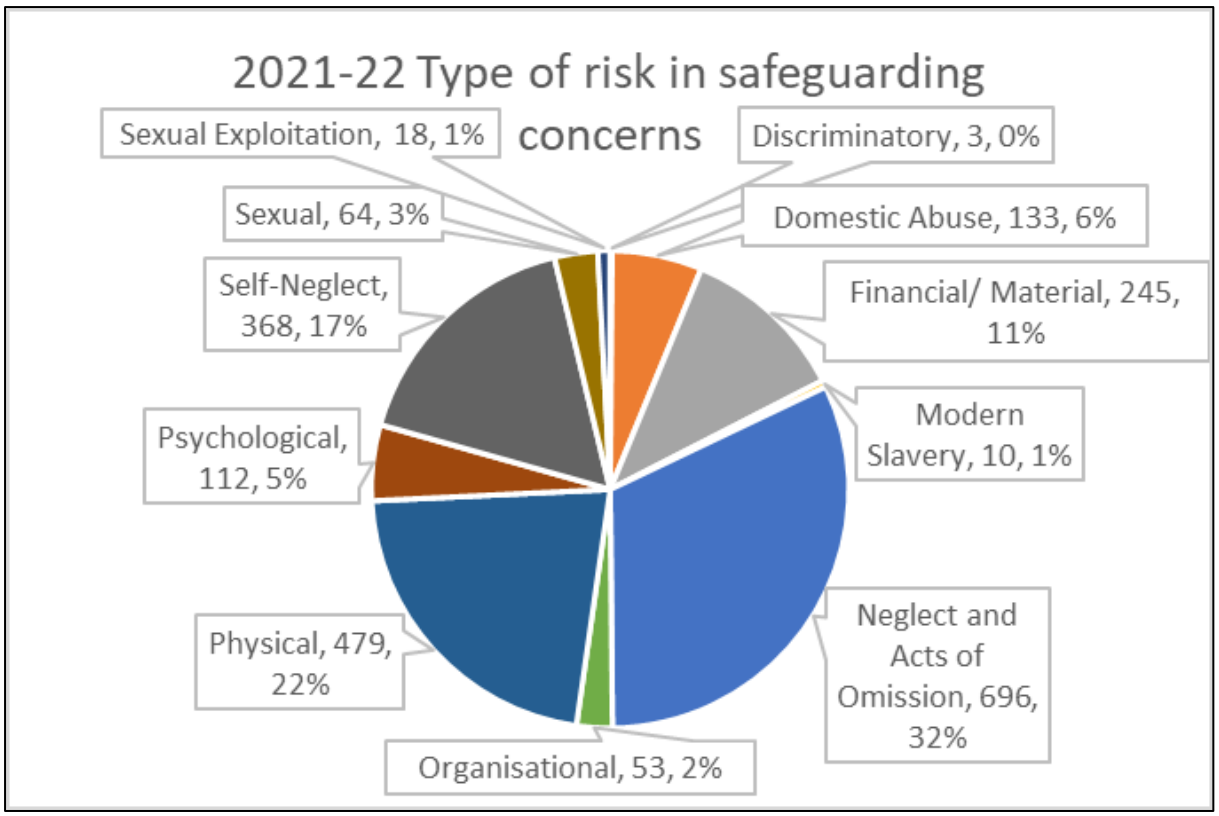
If an issue about an adult's safety or welfare is raised with the MASH, it is called a 'Safeguarding Concern'. The MASH will assess the concern and take appropriate action.

There were 2,181 concerns raised in 2021-22 about 1,502 individuals.

More information about the individuals involved in safeguarding concerns is shown below.


2021-22 Primary Support Reason in safeguarding concerns
Social Support, 156, 9%
Learning Disability, 168, 10%
Sensory Support, 11, 1%
Memory & Cognition, 127, 7%
Physical Support, 434, 25%
Mental Health Support, 325, 18%
No Support Reason, 21, 1%
Not Known, 508, 29%


2021-22 Source of risk in safeguarding concerns
Other – Known to Individual , 625, 29%
Service Provider, 980, 45%
Other – Unknown to Individual , 67, 3%
Self , 509, 23%



If a safeguarding concern meets the criteria from section 42 of the Care Act (see above) a Safeguarding Enquiry will be initiated. The local authority has the power to carry out discretionary enquiries if the criteria are not met.

758 formal Safeguarding Enquiries were concluded in 2021-22.

In 97% of enquiries where risk was identified, action taken led to the risk being reduced or removed.

In line with 'Making Safeguarding Personal (MSP)', where possible, the adult involved in the enquiry will be asked about what they want to happen or what they want to be achieved during the enquiry. In 98% of cases when the adult expressed their desired outcomes, these were fully or partially achieved at the conclusion of the enquiry.

The Board also receives data regularly from Portsmouth City Council housing and trading standards services, Portsmouth Hospitals University NHS Trust, Solent NHS Trust, Hampshire Constabulary, and Hampshire and Isle of Wight Fire and Rescue Service.

In 2021-22 Hampshire Constabulary reported:

- 13 incidents of honour-based violence where the victim was over 18
- 4 incidents of trafficking of a person over 18

- 746 high risk domestic crimes
- 848 incidents of hate crime.

Hampshire and Isle of Wight Fire and Rescue Service carried out 869 Safe and Well visits in Portsmouth in 2021-22.

There were 0 domestic homicides in Portsmouth in 2021-22.

There was 1 fire death in Portsmouth in 2021-22.

Contact us

02392 841786

Portsmouth City Council
Floor 5, Core 5,
Civic Offices
Guildhall Square
PO1 2AL

psab@portsmouthcc.gov.uk

@portsmouthsab

Glossary

4LSAB - The Portsmouth, Southampton, Hampshire and Isle of Wight Safeguarding Adults Boards.

CCG - Clinical Commissioning Group. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

FGM - Female Genital Mutilation

ICS - Integrated Care System. Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services.

LfC - Learning from Cases Committee (a committee of the Portsmouth Safeguarding Children Partnership, which also meets jointly with the Safeguarding Adults Review subgroup of the Portsmouth Safeguarding Adults Board).

LSAB - Local Safeguarding Adults Board

MARM - Multi-Agency Risk Management

MASH - Adult Multi-Agency Safeguarding Hub. A multi-agency team including social workers and police officers which is the first point of contact for adult safeguarding concerns.

MCA - Mental Capacity Act 2005. The Act is in place to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

MSP - Making Safeguarding Personal. A personalised approach that enables safeguarding to be done with, rather than to, people.

NHS - National Health Service

PSAB - Portsmouth Safeguarding Adults Board. A multi-agency partnership which oversees and coordinates work to keep adults at risk safe in Portsmouth.

PSCP - Portsmouth Safeguarding Children Partnership. A partnership which brings together all the main organisations who work with children and families in Portsmouth, with the aim of ensuring that they work together effectively to keep children safe.

SAB - Safeguarding Adults Board

SAR - Safeguarding Adults Review. A multi-agency review process which Safeguarding Adults Boards must carry out to identify learning when an adult at risk dies or is seriously harmed as a result of abuse or neglect, and there are concerns about the way in which organisations worked together to safeguard the adult.

Appendix

What is Safeguarding?

“Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.” (Care Act 2014)

Who are we?

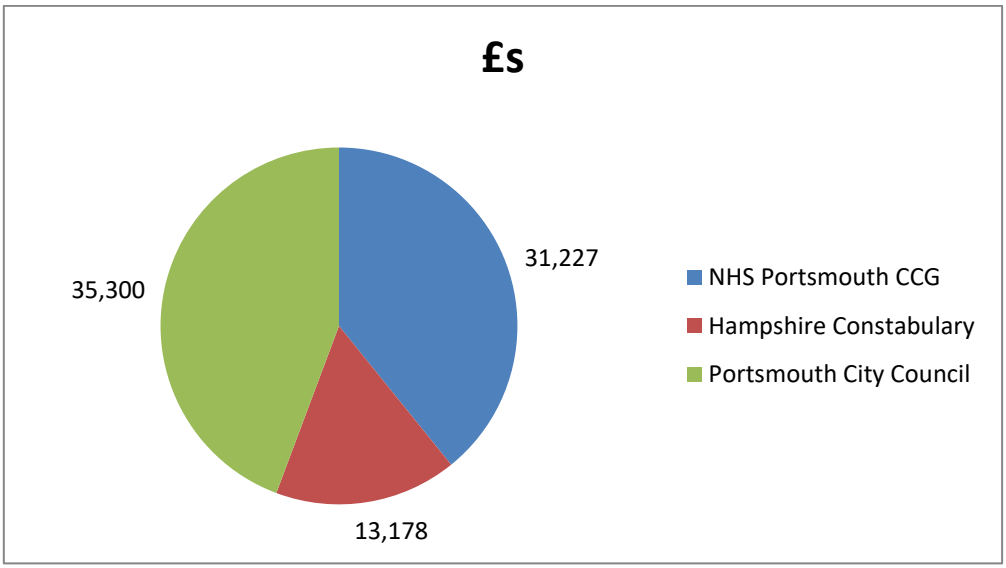
The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- adult social care
- health
- emergency services
- probation services
- housing
- community organisations.

The Board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- offering constructive challenge
- holding member agencies to account
- acting as a spokesperson for the Board.

The Board is funded through contributions from its statutory partners (Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group and Hampshire Constabulary). The contributions received in 2021-22 were:



The structure of the Board and its subgroups is shown in the diagram below. In the areas of policy implementation, fire safety and housing, we have shared '4LSAB' working groups with the neighbouring Boards (Hampshire, Southampton and the Isle of Wight). This helps ensure we work in a joined-up and coordinated way with our partners across the region on common priorities. The addition of a 4LSAB Health subgroup was also approved by the Board in March 2022 and this subgroup will start work from April 2022 onwards.